

# Farley 1

## 4Q/2006 Plant Inspection Findings

---

### Initiating Events

---

### Mitigating Systems

**Significance:**  Dec 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Inadequate Corrective Actions for Main Steam Isolation Valve Failures**

An NRC-identified non-cited violation of 10 CFR 50 Appendix B, Criterion XIV, Corrective Actions, was identified for failure to correct repetitive failures of main steam isolation valves (MSIVs). The April 2006 failure of the three Unit 1 outboard MSIVs to properly operate exhibited similar symptoms to three previous failures which occurred over the period of 2000 to April, 2006. The inspectors identified a number of missed opportunities for the licensee to properly identify and correct the failure mechanisms which led to the most recent failures. The licensee has entered this violation into the corrective action program as CR 2006103043.

This finding is of greater than minor safety significance because it affected the objectives of the Mitigating Systems cornerstone. It affected the availability and reliability of systems that mitigate initiating events to prevent undesirable consequences and the ability of the outboard MSIVs to close. This finding is of very low safety significance because based on the identified failure mechanisms, the inboard valves were generally independent of the outboard valves performance. The finding had problem identification and resolution cross-cutting aspects related to failure of the licensee to thoroughly evaluate problems such that the resolutions address causes and extent of conditions as necessary.

Inspection Report# : [2006005](#) (*pdf*)

**Significance:**  Jun 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Follow Procedures for Containment Closeout**

Green. A Green non-cited violation (NCV) of Technical Specification 5.4, Procedures, was identified by the NRC for failure to follow procedural guidance associated with removal of debris in containment. The licensee performed a containment inspection; however, failed to follow adequate procedural guidance to ensure the containment environment was acceptable for power operations.

This finding is more than minor because it could be reasonably viewed as a precursor to a significant event involving debris accumulation on the containment sump screens and a subsequent impairment to suction flow for Emergency Core Cooling System (ECCS) pumps. Although it impacted the Mitigating System Cornerstone, it did not result in a loss of function per Inspection Manual Chapter (IMC) Part 9900, Technical Guidance, Operability Determination Process for Operability and Functional Assessment, did not represent an actual loss of safety function, and was not potentially risk significant due to possible external events. This finding was entered into the licensee's corrective action program.

Inspection Report# : [2006003](#) (*pdf*)

**Significance:**  Mar 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Promptly Identify and Correct Conditions Resulting in the Unrecognized Inoperability of the 1-2A Emergency Diesel Generator**

A Green, NRC-identified, non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion XIV, Corrective Actions, was identified for failure to promptly identify and correct a failure of the 1F (Unit 1 Train A Engineered Safety Feature) 4-kV bus synchroscope resulting in the unrecognized inoperability of the 1-2A Emergency Diesel Generator (EDG) set.

This finding is more than minor because it is associated with the Equipment Performance attribute of the Mitigating Systems cornerstone and because it affects the associated cornerstone objective. Specifically, the Mitigating System Cornerstone objective is to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences in the future. This finding is of very low safety significance (Green) because there was no complete loss of system safety function and no direct effect on initial accident response or system mission time. This finding involved the cross-cutting aspect of Identification within the area of Problem Identification and Resolution due to cognitive personnel error and knowledge deficiency, in that, it was unclear to the operating crew that loss of the voltmeter indicated that the synchroscope might also be inoperable.

Inspection Report# : [2006002](#) (*pdf*)

---

## Barrier Integrity

**Significance:**  Jun 30, 2006

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **Failure to Control Contractors Results in Fuel Transfer System Damage**

A Green self-revealing non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion VII, Control of Purchased Material, Equipment, and Services, was identified for failure to control adequately contractors during the Unit 1 refueling outage that resulted in damage to the fuel transfer system. This was a self-revealing violation when a pillar block weld broke resulting in damage to the transfer cart, rails, basket, and dummy fuel assembly. The licensee entered the deficiency into their corrective action program for resolution.

This finding is more than minor because it could be reasonably viewed as a precursor to a significant event involving damage to a fuel assembly. Although the damage occurred to a dummy fuel assembly, the stresses applied to the fuel transfer system occurred during core offload and it was fortuitous that the failure happened when a dummy assembly was in the fuel transfer basket. This finding is of very low safety significance because no damage to a fuel assembly actually occurred.

Inspection Report# : [2006003](#) (*pdf*)

---

## Emergency Preparedness

---

## Occupational Radiation Safety

---

## Public Radiation Safety

---

## Physical Protection

[Physical Protection](#) information not publicly available.

## Miscellaneous

Last modified : March 01, 2007